

DOCKET NO. DBD-CV21-6041124-S : SUPERIOR COURT  
PAUL VAN VALKENBURGH and : J.D. OF DANBURY  
DOREEN VAN VALKENBURGH : AT DANBURY  
V. :  
WASHINGTON COBOS and ADRIANA : FEBRUARY 10, 2022  
COBOS

**NOTICE OF SERVICE OF STANDARD INTERROGATORIES  
AND REQUEST FOR PRODUCTION**

Pursuant to Practice Book §§13-6(c) and 13-9(b), the Defendants in the above action hereby give notice that they are directing to the Plaintiffs, **DOREEN VAN VALKENBURGH AND PAUL VAN VALKENBURGH**, Practice Book Interrogatories and Requests for Production:

\_\_\_\_\_ Forms 201 and 204 (Directed to Defendant)

XXXXXXXX \_\_\_\_\_ Forms 202 and 205 (Directed to Plaintiff)

\_\_\_\_\_ Forms 203 and 206 (Directed to Defendant - Premises)

To be answered under oath within sixty (60) days hereof.

**PLEASE NOTE:** The included authorization must be completed in full including the treating doctor/providers full name, business address and treating office address.

THE DEFENDANTS,  
ADRIANA COBOS AND WASHINGTON  
COBOS

By \_\_\_\_\_ /s/433656  
Denise Penn, Esq.  
**Law Offices of Meehan, Di Palma, Roberts  
& Turret**  
Tel. # 203-294-7800  
Juris # 408308

**CERTIFICATION**

This is to certify that all personal identifying information was redacted pursuant to *Practice Book Section 4-7*. This will further certify the foregoing was mailed via U.S. Mail, postage pre-paid or electronically delivered pursuant to *Practice Book Section 10-14* on this 10th day of February, 2022.

**Attorney for Plaintiff**

Brian T. Romano, Esq.  
The Law Offices of Brian T. Romano  
235 Main Street, Suite 104  
Danbury, CT 06810  
[brian@bromanolaw.com](mailto:brian@bromanolaw.com)

\_\_\_\_\_/s/433656  
Denise Penn, Esquire  
Commissioner of the Superior Court

**PLAINTIFF'S CERTIFICATION**

I, **DOREEN VAN VALKENBURGH**, hereby certify that I have reviewed the above Interrogatories and Requests for Production and responses thereto and that they are true and accurate to the best of my knowledge and belief.

\_\_\_\_\_  
Doreen Van Valkenburgh,

Subscribed and sworn to before me this \_\_\_\_\_, day of \_\_\_\_\_, 20\_\_.

\_\_\_\_\_  
Commissioner of the Superior Court/  
Notary Public

**AUTHORIZATION FOR THE RELEASE AND  
TRANSFER OF EMPLOYMENT INFORMATION**

**TO:**

I, the undersigned, hereby consent and authorize you to disclose and release to agents, servants, and employees of the Law Offices of Meehan, Di Palma, Roberts & Turret, P.O. Box 6835, Scranton, PA 18505-6840 (including any physician(s), nurse(s), and expert witness(es) retained or consulted by the Law Offices of Meehan, Di Palma, Roberts & Turret, and the liability insurer of the Law Offices of Meehan, Di Palma, Roberts & Turret client in connection with my claim), and any arbitrator(s), appointed to hear my claim, the following confidential information, to order, inspect, copy and/or reproduce any and all records arising from my hire/enlistment with you, including but not limited to wage information, pre-employment/pre-enlistment physicals, physicals thereafter, attendance, personnel, clinic and/or hospital records.

I authorize the transfer of said information by and between the aforesaid persons.

I am informed that the above information requested is needed and is to be used for pursuing the disposition of my claim arising out of an alleged accident on **October 4, 2019**. This consent for the release and transfer of said information may be withdrawn at any future time and is subject to revocation by me when transmitted in writing, except when signed in connection with a claim for benefits under any insurance policy in which case it shall be valid during the pendency of that claim.

I agree that a photocopy of this Authorization be accepted with the same authority as the original.

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

SS#: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION**

I, hereby voluntarily consent and authorize you, in accordance with 45 C.F.R. Sec. 164.508, to use or disclose health information including, if applicable, information relating to the diagnosis or treatment of mental illness, drug and/or alcohol abuse and confidential HIV/AIDS related information, only for the purposes and parties described below. This authorization permits you to disclose all medical, psychiatric, drug and/or alcohol abuse, HIV information, records, x-rays, films, bills, reports, or copies thereof relating to my examination, consultation, confinement, or treatment by you. This release also authorizes the disclosure of any and all payment records, billing records and insurance related information.

**Purpose for Disclosure:**

Civil Litigation: Personal Injury Lawsuit \_\_\_\_\_

Workers' Compensation Claim \_\_\_\_\_

**Name of Health Care Provider to make Disclosure:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Records to be disclosed to:**

Meehan, Roberts, Turret & Rosenbaum  
108 Leigus Road, First Floor  
P.O. Box 5020  
Wallingford, CT 06492

Liberty Mutual Group, and its affiliates  
175 Berkeley Street  
Boston, MA 02116

ABI Document Support Services  
1122 Franklin Avenue, Suite 300  
Garden City, NY 11530

**Description of Records to be Disclosed:** *My full and complete medical file and billing records* including but not limited to: office notes, doctor's notes, nurse's notes, billing records, treatment plans, laboratory results, diagnostic test results, records of other physicians in your chart, radiological results, history, physical exam, discharge summaries, operative records, consultations, same day surgery records, emergency room records, ambulatory care records, rehabilitation records, therapeutic records, psychiatric records, psychological records, counseling records, pathology records, cytology records, cardiology records, neurology records, orthopaedic records, physiology records, hematology records, oncology records, chiropractic records, CT scan reports and films, MRI reports and films, X-ray reports and films, imaging reports and films, ultrasound records, immunization records, medication records, etc.

**Patient Name and Address:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Patient Date of Birth:**

\_\_\_\_\_  
**Dates of Treatment:**  
\_\_\_\_\_

**This Authorization shall remain in Effect for one year from date below.**

I understand that I may cancel this authorization at any time by notifying you in writing, but if I do it will not have any affect on actions that the provider took before it received the cancellation. Furthermore, the information disclosed under this authorization may be subject to further disclosure by the recipient and thus, no longer protected by state or federal privacy regulations.

I understand that my treatment or continued treatment by you is in no way conditioned on whether or not I sign this authorization and that I may refuse to sign it.

I am entitled to a copy of this authorization, and acknowledge receipt of a copy. I understand that I may inspect or copy the information disclosed under federal regulations.

The patient's parent or legal guardian must sign this authorization if the patient is a minor (under age 18) or has a legal guardian. Minors may sign their own authorizations for records relating to drug/alcohol abuse treatment, sexually transmitted diseases or HIV/AIDS related diagnosis, and in certain circumstances, Mental Health treatment records.

I understand that you may receive compensation as set by law for copying and processing fees related to the use/disclosure of my health information under this authorization.

I agree that a photocopy of this Authorization has the same authority as the original.

\_\_\_\_\_  
Signature of Patient or Authorized Representative

\_\_\_\_\_  
Date

If patient has not signed this form, please indicate the relationship of the signatory to the patient.

\_\_\_ Parent/Guardian \_\_\_ Administrator/Executor of Estate \_\_\_ Power of Attorney/Conservator \_\_\_ Other-specify

**PLAINTIFF'S CERTIFICATION**

I, **PAUL VAN VALKENBURGH**, hereby certify that I have reviewed the above Interrogatories and Requests for Production and responses thereto and that they are true and accurate to the best of my knowledge and belief.

\_\_\_\_\_  
Paul Van Valkenburgh,

Subscribed and sworn to before me this \_\_\_\_\_, day of \_\_\_\_\_, 20\_\_.

\_\_\_\_\_  
Commissioner of the Superior Court/  
Notary Public

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I authorize the transfer of said information by and between the aforesaid persons.

I am informed that the above information requested is needed and is to be used for pursuing the disposition of my claim arising out of an alleged accident on **October 4, 2019**. This consent for the release and transfer of said information may be withdrawn at any future time and is subject to revocation by me when transmitted in writing, except when signed in connection with a claim for benefits under any insurance policy in which case it shall be valid during the pendency of that claim.

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Garden City, NY 11530

**Description of Records to be Disclosed:** *My full and complete medical file and billing records* including but not limited to: office notes, doctor's notes, nurse's notes, billing records, treatment plans, laboratory results, diagnostic test results, records of other physicians in your chart, radiological results, history, physical exam, discharge summaries, operative records, consultations, same day surgery records, emergency room records, ambulatory care records, rehabilitation records, therapeutic records, psychiatric records, psychological records, counseling records, pathology records, cytology records, cardiology records, neurology records, orthopaedic records, physiology records, hematology records, oncology records, chiropractic records, CT scan reports and films, MRI reports and films, X-ray reports and films, imaging reports and films, ultrasound records, immunization records, medication records, etc.

**Patient Name and Address:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Patient Date of Birth:**

\_\_\_\_\_

**Dates of Treatment:**

\_\_\_\_\_

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